MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

September 25, 2007
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Tuesday, September 25, 2007 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Janet Cowell, James Forrester, Vernon Malone, and William Purcell and Representatives Jeff Barnhart, Bob England, Jean Farmer-Butterfield, Carolyn Justus, and Fred Steen. Advisory members, Senator Larry Shaw and Representatives Van Braxton and William Brisson were present.

Kory Goldsmith, Shawn Parker, Susan Barham, Andrea Poole, Melanie Bush, and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Senator Martin Nesbitt, Co-Chair, called the meeting to order welcoming returning members, new members, and guests. He announced the new members joining the committee which included Senator Bob Atwater, Representative Jean Farmer-Butterfield and Representative Carolyn Justus. Advisory members introduced were Senator Larry Shaw, Representative Van Braxton, and Representative William Brisson. Members then introduced themselves and gave a brief description of their interest in mental health, developmental disabilities, and substance abuse services (MH/DD/SAS) and their backgrounds. Senator Nesbitt asked for a motion to approve the minutes from the March 6, and March 7, 2007, meetings. Representative Barnhart made the motion and the minutes were approved.

Senator Nesbitt said that he felt optimistic about the future of the mental health system. He said that steps had been made to move the system in the right direction and that some of the things that the Committee had been working on would begin to take place over the next year.

Senator Nesbitt introduced Dempsey Benton, Secretary of the Department of Health and Human Services (DHHS). Secretary Benton said he looked forward to working with the Committee and working to ensure that the MH/DD/SAS program provides services to consumers and their families as needed in North Carolina. He said the Governor wanted to do as much as possible in the next 18 months of this administration to fix the MH/DD/SAS system. He stated that the Governor said we need to enhance the accountability and effectiveness of the programs while identifying any long-term structural adjustments that need to be made administratively, and if necessary through changes in statutes. Secretary Benton said that he had met with various groups and

stakeholders to gather input on how to obtain the common goal of a public system that works for consumers and their families.

He said that some of his top priorities were to implement the crisis services system, and to fully utilize the State Consumer Family Advisory Committee (SCFAC) which could provide feedback and guidance to improve the system. Other priorities were to increase provider capacity, and enhance substance abuse treatment facilities. Secretary Benton also said that there were a wide range of challenges. He said that the Department would provide guidance, direction, and support to Broughton and Cherry hospitals to ensure that problems with Medicaid and Medicare would be fixed. He estimated that the loss of federal revenue at Broughton hospital over the 30-45 day period would be approximately $1.2 million. He said the budget for Broughton hospital was about $19.2 million in receipts to supplement the State appropriations. He said the Department would be working to recover what might be lost during the interim period. Other challenges mentioned were the indigent and those with severe substance abuse issues. He said that stability was important, but we also needed to include achieving a level of sustainability in the financial and budgetary areas, the provider network, and getting statewide services, and improving the State Local Management Entities (LMEs) network.

Secretary Benton explained that the Division of Mental Health, Developmental Disability, and Substance Abuse Services, (Division) contracted Dr. Alice Lin to perform an environmental scan of the reform effort looking in other states, and to assess the implementation of the LMEs. He pointed out that Dr. Lin had over 35 years of experience in the MH/DD/SAS system, working at all levels of the public system. He stated that Dr. Lin would continue to work with DHHS over the next year as a senior advisor. With that, Dr. Lin came forward to present her report on *The Implementation of Local Management Entities*. (See Attachment No. 2)

Dr. Lin recognized the contribution of those involved in the review for their time and effort. She described the shared sense of frustration as the background for the review, and she was asked to conduct an environmental scan of relevant states to bring lessons from reform experiences elsewhere and to assess whether the LME implementation was consistent with the statutory framework, and to identify its strengths and weaknesses, and action steps moving forward. She was encouraged to hear a renewed sense of confidence today about the reform.

Dr. Lin explained the criteria used for both the environmental scan and LME review; Four states (Georgia, Ohio, Pennsylvania, Texas) were selected with good reform experiences and states in the same and different CMS regions, and seven out of twenty-five LMEs were selected (Durham, OPC, Five-County, Crossroads, Southeastern, Sandhills, Western Highlands) that represent geographic differences, varying implementation time frames, but not those currently involved in mergers.

Dr. Lin walked the LOC members through findings of the environmental scan and a review of LME implementation tasks, highlighting the positive accomplishments as well

as weaknesses and unfinished tasks. She ended with immediate, short-term, and mid-term recommendations. (See Attachment No. 2)

Senator Nesbitt asked the LOC members for follow-up questions.

Dr. Lin was asked how the quality of care is assessed in providers, and if she looked at the use of vouchers which are used in Florida. She responded that she was only aware of the cash and counseling voucher program for long-term care in Florida. In terms of assessing quality of care, it should start with clear expectations for the providers. A report card should be developed for the providers with LMEs assessing how they are performing their functions. She said other states have used report cards and engaged consumers as part of the review process. Dr. Lin was also asked to address consumer access in North Carolina after reform. She indicated that North Carolina has not made much progress in terms of serving those individuals that have fallen through the cracks in the past. She said the State has become better in terms of expanding eligibility for consumers who can access new services that were not available before. There are more evidence based practices and new services than before reform, such as increased in-home support, ACT (Assertive Community Treatment), and MST (Multi-Systemic Treatment).

Dr. Lin was asked what basis was used to determine that 85% of consumers were being reached and 15% were not. The percentage is based on the informal survey of consumers screened through the STR system and comparable data from other states. In North Carolina, about 15% of consumers had difficulty obtaining services due to a number of factors: (a) no Medicaid eligibility, (b) challenging consumers (substance abuse, behavioral problems that require expert interventions), and (c) lack of provider capacity in serving them.

Next, she was asked how it was determined who needs services from the public sector. Dr. Lin responded that needs assessment is usually done at the State level to provide a rational basis for determining needs. North Carolina should have all 4 core services available across the State. Senator Nesbitt reiterated that the lack of statewide information is a problem, and in addition, the completed needs assessment did not capture local county contributions. He said that hopefully information would be forthcoming so the committee could better analyze the system needs.

Dr. Lin was asked if consolidation had affected services at the local level. She responded that overall consolidation did impact consumer access especially where consumers were directed to new providers. Consolidation worked well in terms of management, fiscal, and personnel consolidation.

She was asked if all computer systems were compatible throughout the LMEs, and if there was uniformity in the billing process. Dr. Lin stated that IPRS system for non-Medicaid funding is uniform, but LMEs have their own computers systems that are not always compatible. She suggested that a comprehensive evaluation might help determine if the LMEs are performing well in this area.

Finally, Dr. Lin was asked what could be done to adequately address long-range planning without being sidetracked by the immediate crises that seems to divert the process. Dr. Lin stated that the State Plan was an important tool and a good starting point. She said due to the many changes in the environment, a short-term plan (2 years) is important as well as a long-term plan. The plan must be reality based and anticipate problems.

After lunch, Kory Goldsmith, Research Division, reviewed a portion of the special provision from the budget this year related to *Crisis and Acute Care Services*, Section 10.49.(t). (See Attachment No. 3) She explained that there were several statutes relating to a process that the Department and the Counsel of State go through in the event there is a closure of one of the State operated facilities. This statute does not apply since the special provision gives the Secretary the authority to close Dorothea Dix Hospital and John Umstead Hospital provided certain conditions are met.

Next, Senator Nesbitt welcomed several legislators who had joined the meeting to participate in the discussion regarding the closure of the Dix and Umstead hospitals. He then recognized Jim Osberg, Chief of State Operated Services from the Division of MH/DD/SAS. Dr. Osberg addressed the closure of Dorothea Dix and John Umstead Hospitals pursuant to the opening of Central Regional Hospital (CRH) in Butner. (See Attachments No. 4 and No. 5) Dr. Osberg gave a brief overview of the legislation and studies that provided the basis for downsizing. He then provided a timeline for the design, construction, and operation of CRH. Referring to the closure plan, Dr. Osberg said Table 1 and Table 2 displayed services to be provided at CRH, and that services would equal or exceed the number of bed services provided today at Dix and Umstead combined. He said the Adult Admissions column best captured the short-term admissions. He also stated that CRH had the capability to expand its capacity by converting several rooms to double occupancy if necessary.

Andrea Poole, Fiscal Research, was recognized to give comments from staff on the plan for closure of the hospitals. (Comments were based on the actual report and not on comments given during the meeting from Dr. Osberg.)

- The Closure Plan does not adequately discuss the ability of the new hospital and the catchment areas (LMEs) to meet the long term secure as well as acute care needs of consumers. It discusses the number of beds pre- and post-closure of the hospitals, but that does not provide information regarding whether those numbers meet, exceed or do not meet consumer needs.
- The Closure Plan provides a list of crisis services providers as reported by LMEs in September, 2006. This does not provide current information regarding whether those services still exist, whether new service providers have subsequently come on line, or how many consumers can actually be served by any particular service provider. The Closure Report only discusses a few of the housing programs available to serve this population and does not give an inventory of existing capacity in the catchment area for appropriate housing.
- The Closure Plan contains a count of providers of Intensive Support Services rather than capacity information by using Medicaid paid claims data, so it is not clear what the capacity for non-Medicaid eligible populations would be.

- The Closure Plan does not do a thorough job of estimating impact to the other facilities (particularly Cherry Hospital). It estimates the increase in the covered population, but does not attempt to estimate the actual increase in patients.
- The "plan" part of the Closure Plan is not included. The legislation did not specifically call for things such as the logistics of closure, coordination with LMEs or timeline for the move, but without this information, the Closure Plan is not complete.

Addressing growth projections, Dr. Osberg was asked what the growth had been in the hospitals over the last few years and how long it be before CRH would reach its growth maximum. He responded that Dix had about a 10% increase in adult admissions annually. Overall, in all 4 hospitals from 2000 to 2007, there had been approximately a 20% increase in all admissions. Expectations are that the number of adult admissions would decrease with crisis services implemented. Currently, an increase in capacity at ADATC facilities for acute substance abusers is taking place, and he said the pilot project should have an impact on admissions. Mr. Osberg was asked to provide an analysis regarding admissions in the next report.

Concerns regarding the closure of Dix Hospital by legislators included:

Representative Deborah Ross pointed out that the hospital could not be closed until the requirements in the statute had been met. She proceeded to cite sections in statutes not met in the report. She said the report did not address the actual need in the catchment area; did not address the capacity for patients to access crisis services, local hospital psychiatric beds, intensive support services; and did not address how the State would attract private providers for state paid non-Medicaid clients, how to deal with dangerous people; and did not address the impact the closure would have on Broughton and Cherry hospitals.

Senator Neal Hunt asked what provisions had been made to take care of critically ill people currently being turned away for lack of beds. Mr. Osberg answered that when a State hospital exceeds 110% of operating capacity, it goes on diversion status. The hospital attempts to admit patients to one of the other State hospitals. He said they also checked with private or medical hospitals with psych units for availability, but if there is no room the patient is put on delay, and admitted when an opening at a State facility becomes available. Senator Nesbitt said that Broughton and Cherry hospitals needed to be up to par if they were to be used as safety nets. Senator Hunt also asked how the new facility would resolve this issue. Mr. Osberg answered that the facility would not resolve the problem with the current resources in the State hospitals, but that crisis services and substance abuse detox services were an alternative. Mike Moseley, Director of the Division of MHDDSAS, added that there were broader systems issues that must be addressed if we are to reduce the utilization of the hospitals. One is the increase in funding for community based crisis services and second, is the transformation of the alcohol and drug abuse treatment facilities. The Walter B. Jones facility and the R.J. Blackley facility are in the process of opening beds adding 35 additional beds in the central region. Third, is the substance abuse focus in the community. He said that 35% to 40% of admissions to psychiatric hospitals, in terms of short-term acute units, are people

with substance abuse issues. He said that there were other issues, but those issues can not be resolved by the new hospital, they will have to be resolved by other developments in a broader system. Senator Nesbitt asked for an analysis of what is expected to be gained in the other systems so there would be benchmarks to review.

Representative Jennifer Weiss questioned the numbers on the chart on page 2 of the presentation, Operating/Staffed Capacity. Comparing an internal Daily Nursing Statistical report given to her by the Division, Representative Weiss questioned why the total capacity showed 359 while the presentation to the committee showed 307. Dr. Osberg stated the numbers do not reflect the beds that are able to be operated and staffed. The chart indicates the actual number of beds based on core staffing. She also pointed out that the Daily Census was very different than the Average Daily Census presented. Representative Weiss also asked why overflow and expansion numbers were given for CRH but not for Dix and Umstead hospitals. Senator Nesbitt requested that the Division make revisions and report back to the committee and include information on the maximum and minimum number of beds provided by the hospitals. Representative Weiss and Senator Stevens requested additional information in the next report on the overflow unit at Broughton, the services offered to children and adolescents at that unit, financing, and how they will compares to existing services at Dix and Umstead.

Representative Barnhart asked when planning the new hospitals, if a 5 to 10 year projection could be made in a chart to address capacity. Mike Moseley responded that the Department had looked at the general population growth in North Carolina spread across various counties, and how redrawing regional lines would affect capacity. Some counties are moving before switching from a 4 region model to a 3 region model. He said that right now it was uneven, but they were trying to balance the distribution. They were also trying to be sensitive to geographical distance for consumers.

Senator Richard Stevens said he would like to see the adequacy of private providers addressed in the next report.

Representative Pat Hurley expressed her concern over the issue of capacity in the hospitals, reiterating other legislators concerns.

Representative Nelson Dollar requested that the report address staffing issues: where the staffing specifically is, how it is going, and what is going to be done to ensure that there is sufficient staffing to service the beds listed.

Representative Verla Insko, Co-Chair, requested that information be included regarding the school for school age children at Dix, and whether or not a school would be established at CRH. She also asked for a detailed description of the plan to attain adequate staffing for CRH, and what would happen to the staff at Dix. She said her greatest concern was that people were not being discharged properly, and that they were not being kept long enough. She asked what the true need was to keep people long enough to see that they were stabilized and she requested a full gaps analysis.

Next, Andrea Poole and Melanie Bush from Fiscal Research reviewed the money items in the budget and the special provisions. (See Attachment No. 6) The spreadsheet summarized what was done with MH/DD/SAS items in the budget, and how each was funded. Ms. Poole said some funds that were unspent at the end of the year were realigned and put to different uses. Some money spent was new money, some was realigned from somewhere else, and some was spent based on projected savings from the hospitals.

Continuing, Ms. Poole and Ms. Bush then reviewed the summary of the mental health provisions and noted the actual provisions were included for reference. (See Attachments No. 7 and No. 7A)

Senator Nesbitt commented that $70 million that was requested of the General Assembly was additional dollars in substance abuse and mental health. In March it was discovered that money was being diverted in both areas. He indicated that additional money can not be requested when you are not spending what you allocate. The lack of the provider network seems to be the problem so attention has turned to strengthening that network. Senator Nesbitt was asked if it was reasonable to expect CRH to open in 90 days with a smooth transition, and if the date was changed, would that be an administrative decision or a legislative decision. Senator Nesbitt responded that legislative commissions and committees have no executive powers. Legislation is clear in what needs to be done prior to opening the new hospital. He said right now it is a work in progress, and to wait and see what the Department brings next month.

Kory Goldsmith, Research Division, gave a brief summary of non budgetary items. (See Attachment No. 8) She briefly explained 3 bills that the General Assembly passed: Mental Health Parity coverage for insurance; Uniform Graduated Co-payment for MH/DD/SAS; and the extension of The First Commitment Pilot Program/LME Functions and Administrations.

Shawn Parker from the Research Division provided 3 documents with an update of the LMEs. 1) A map of the current LMEs; 2) A chart with contact information for each of the 25 LMEs, their catchment and population; and 3) An historical document charting the counties movement since 1997. (See Attachments No. 9, No. 10 and No. 11)

Trisch Amend, NC Housing Finance Agency and Julia Bick, DHHS, gave an update on the Housing 400 Initiative. The packet distributed contained a memo outlining what has been done and will be done with the 2008 appropriation, a list of the 64 properties where housing will be available, and a map displaying the 33 counties where the housing is located. (See Attachment 12) Ms. Amend announced that financing for housing for persons with disabilities at incomes at the SSI level had been awarded for 425 units in 33 counties.

Jim Osberg gave an update on the hospital utilization pilot. He said that legislation mandated that $2,250,000 be distributed to up to 3 LMEs in one region and to 1 or more LMEs in another region, and community services must be developed in order to decrease

utilization of State psychiatric hospitals. He said that the RFA had gone to all LMEs on August 31. Dr. Osberg said the LMEs were developing their responses to the proposal which is due October 15. The Division will make the award November 1, with implementation on January 1, 2008.

Phillip Hoffman, from the Division, reported on data collection. (See Attachment No. 13) He stated that legislation required LMEs to report consumer income. He pointed out that family size was not required in the special provision, but that in order for the income data to be meaningful, the family size was needed. Implementation of recording data would occur in stages beginning with new consumers in January 2008. He said for consumers already receiving services prior to January 2008, there would be a process for LMEs to go back in the records and update information in the data warehouse. He said that after this was completed, income data for the entire year would be available for persons served. This information will show who the unserved population is.

Mr. Hoffman reported that a workgroup had been established to address the use of county funds. The group was instructed to draft a proposal on how to collect the information on the utilization of county funds. The provision requires an annual report on the utilization of county funds. The Division anticipates having all the information by the end of the year.

Dr. Bonnie Morrell, from the Division, reported on the crisis services implementation. She said consultants worked with the Division around the planning and implementation of crisis services. All plans were submitted by the LMEs by March 1, reviewed by the Division, modifications made by the LMEs, and as plans were approved, programs were implemented using start-up funding from last session. For FY 2006-2007, $7 million in recurring funds were used for local inpatient services, facility based crisis, detoxification, and mobile crisis. Medicaid covered a small share of these services. Dr. Morrell was encouraged that through crisis services, admissions to State hospitals showed a decrease from July 2007 compared to July 2006 of 268 admissions, and from August of 2007 to August 2006 there had been a decrease of 365. She concluded that a full array of crisis services would take additional work and effort especially those with developmental disabilities (DD) who need different kinds of services from the community. Quarterly written reports regarding LME crisis plans will continue to be provided to the committee.

Flo Stein, from the Division, said that the actual report on performance indicators would be delivered on October 1. Sharing some of the information in the report, she said that LMEs reported that persons in crisis seeking emergency care in the last quarter, almost all had received care within 2 hours. This improvement kept people from going to hospitals and kept them out of jail. She said one goal was to move more people to CAP slots and with help from the General Assembly, those slots had increased 50% over 2 years ago with 9,300 people currently being served. She said LMEs able to provide continuity were seeing significant improvement in mental health and substance abuse clients in every measurable indictor. Ms. Stein said the report also showed that there was still a significantly low number of persons with substance abuse disorders receiving services; there was still a shortage of providers in certain areas; and that there had been a

slow-down in the number of people being moved from DD centers into the community. She said DHHS was working with consultants on a new strategic plan. They would look at stabilizing/standardizing the LME provider system, ensuring comprehensive crisis services, improve housing, and improve supports in employment. She pointed out that all the data is based on the data management system, and as we move to more flexibility, we must shift where we put our emphasis on data collection. She said there still must be flexible money and data otherwise it will not be known if the flexible money is working if it is not known who the money is being spent on, what it is purchasing, and to what effect.

There being no further business, the meeting adjourned at 3:30 PM.

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Senator Martin Nesbitt, Co-Chair	Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant